FRAUD IN THE CALIFORNIA MEDI-CAL PROGRAM

Presented by California State Controller

Kathleen Connell

July 18, 2000

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Message From California State Controller Kathleen Connell

United States Congressional House Commerce Committee's Subcommitee on Oversight and Investigations, July 18, 2000

The Controller of the State of California is a state constitutional officer elected by the voters. As State Controller, I serve as the State's chief financial officer.

I have produced this report specifically for the United States Congressional House Commerce Committee's Subcommittee on Oversight and Investigations relative to the July 18, 2000 hearing on Medicaid fraud. This report provides a history of the efforts of my office as well as detailed statistics on our efforts.

At the beginning of my administration in 1995, I set the elimination of waste and fraud in state programs as my highest priority. The Medi-Cal program, California's version of the Medicaid program, was then, and continues to be, one of the most significant parts of California's annual budget. In the current fiscal year, over $22.5 billion is appropriated for Medi-Cal, of which $13.2 billion is federal funds. General fund expenditures of over $9 billion for Medi-Cal will account for nearly 12% of all General Funds in the state budget.

Early in my administration, I directed auditors to expand the review of billing practices of Medi-Cal providers. In June 1996, my office issued a report on 11 pharmacy providers in Long Beach, California, that identified over $2 million in unallowable costs. Significantly, two of the eleven closed their businesses immediately after the auditors arrived. This raised concerns that there were additional areas of apparent fraud that had not been previously identified.

The California State Controller's Office then expanded its efforts into other provider categories and found similar results in audits of durable medical equipment providers, physicians, and laboratories. To date, the California State Controller's Office has issued 367 reports, demanded repayment of $141 million, saved the taxpayers an additional $385 million in cost avoidance, and withheld $23.5 million in payments to providers identified by law enforcement as engaging in fraudulent activities. The total savings from the efforts of our office are over $547 million, more than one-half of which is federal funding. In addition, the California State Controller's Office referred 238 cases to the Medi-Cal Fraud Control Unit of the California Department of Justice for criminal investigation and prosecution.

In 1998, seeking to pursue criminal prosecution of our Medi-Cal findings, the California State Controller's office initiated a partnership with the Federal Bureau of Investigation, the U.S. Attorney General's Office, and the California Department of Justice to pursue criminal investigations and subsequent prosecution.

To assist the California Department of Health Services in carrying out its administrative responsibilities, the California State Controller's Office sponsored legislation that gave that Department more authority to tighten up the provider

enrollment process, increase penalties for fraud, and expand the use of bond requirements. This legislation was signed into law last year, and it represents a significant change in the way we operate Medi-Cal in California. Please refer to chart 4 in my report, which outlines the specifics of these legislative changes.

The California State Controller's Office has also participated in the newly created California Governor's Task Force on Medi-Cal Fraud, which is intended to coordinate the efforts of all state and federal agencies involved in anti-fraud efforts in Medi-Cal.

The increased anti-fraud activities from all of these agencies, which resulted from our initiatives, are having a significant effect. The California Legislative Analyst noted that 31% of the providers of durable medical products – one of the first provider types to be targeted by my auditors – have been removed from the provider roles and that claims for this group have declined by nearly 10%. In addition, the California Legislative Analyst anticipates similar results in the future in other provider types that our office's audits have targeted.

While this is good news, it is also clear that fraudulent providers have noticed these efforts and are taking steps to circumvent the current prevention and detection efforts. New schemes involve:

- Using false identification to masquerade as licensed providers who are retired, no longer practicing in California;

- Using marketers to pay beneficiaries to use their Medi-Cal card to bill for services that are unnecessary or not provided;

- Stealing beneficiary Medi-Cal information from hospital records and using it to bill for services not provided;

- Buying an established health care business and billing under that name; and

- Developing some documentation to avoid detection by performing unnecessary invasive procedures (for example, drawing blood) and then billing for tests never performed. In addition to the health risks to the person having this type of procedure, this practice can increase the possibility of the spread of disease in the general population.

It is clear that the fight against fraud in the Medi-Cal program is still far from over. There are two concerns regarding the future of Medi-Cal anti-fraud efforts that are addressed in this report.

First, recent federal court rulings have minimized the California State Controller's Office's role in combating Medi-Cal fraud and abuse. Without our efforts to identify the problem and take action, Medi-Cal provider fraud could have gone unnoticed and/or untreated for long periods of time.

While much has been accomplished, it is clear that this is a problem that will require long-term dedication by state and federal officials.

Second, recent federal court rulings have undermined the California State Controller's Office ability to carry out a critical oversight role, limiting the office's ability to conduct audits. In addition, the California State Controller's Office is currently prohibited from initiating withholds on payments to suspected fraudulent providers or referring them to the Department of Justice for criminal investigation and prosecution. Cracking down on fraud cannot occur without the ability to stop the flow of funds. Under the current court rulings, even when fraud is detected, the California State Controller's Office cannot withhold payment nor even inform the California Department of Health Services that fraud is suspected. Only a report can be submitted with the intention that the California Department of Health Services would recognize the fraudulent activity. As a result, our payments may be continued for some time. Even when prosecution is successful, those additional payments are often not recovered.

Essentially, the federal courts have interpreted federal law and regulations regarding the "single agency" requirement to require that the California State Controller's Office not engage in any activities in which it might exercise any discretion.

Even though the California State Controller's Office has an independent duty under California law to determine the legality and propriety of payments made from the State Treasury, the federal courts have determined that the State of California modified this duty when it accepted federal money and agreed to be bound by federal Medicaid law.

In order to solve this problem and allow states to adequately combat fraud, I request that Congress take action to review and amend the Single State Agency law to allow recognition of the State's constitutional role of its elected officials and thereby allow me to once again carry out my independent duties and responsibilities as the state's fiscal watchdog.

Such an action on the part of Congress would send a clear message to criminals considering committing Medicaid fraud and undermining the program goals, that both federal and state government are serious about prevention, detection, and prosecution, and that such criminal activity would have its consequences.

KATHLEEN CONNELL
California State Controller

Fraud in the California Medi-Cal Program

Background

The California Medi-Cal program, which is administered by the California Department of Health Services, is California's version of the federal Medicaid program. Medi-Cal provides health care services to approximately five million public assistance recipients and other needy individuals in California. According to the Governor's budget proposal, California will incur an estimated $22.5 billion in Medi-Cal program expenditures for the 2000-01 fiscal year ending June 30, $9.2 billion of which comes out of the State's General Fund.

Medi-Cal employs a "fee-for-services" system to pay for medical services for approximately 50% of the recipients and a "managed care" system to pay for medical services for the remaining recipients. Under the fee-for-services system, after services are furnished, providers submit invoices to Electronic Data Systems, which serves as the State's Medi-Cal fiscal intermediary. Under managed care, the California Department of Health Services contracts with public and private health maintenance organizations to provide medical services to beneficiaries at predetermined, or "capitated" rates. The rates are based on the cost of serving beneficiaries in the fee-for-services system.

More than 81,000 providers, broadly classified into "institutional" and "non-institutional" providers, are currently providing medical services to Medi-Cal beneficiaries. Institutional providers are those that provide in-patient services, such as hospitals and nursing homes. All other providers are categorized as non-institutional providers.

Since 1979, the California State Controller's Office has played an integral role in auditing provider claims submitted for payment. These audits were performed in compliance with California constitutional and statutory requirements mandated upon the California State Controller as part of the office's state constitutional responsibilities.

In June 1996, the California State Controller's Office expanded its California audit efforts pursuant to an interagency agreement with the California Department of Health Services and conducted a review of 11 pharmacy providers in Long Beach, California, all of which were clustered in a small geographic area. A preliminary review showed that these Medi-Cal providers' billings were inflated by an average of 75%, amounting to $2 million in questioned costs for the period audited.

As a result of the review of the pharmacies, the California State Controller directed that the Medi-Cal audit effort be expanded to other types of providers and to document the systemic nature of the abuse in the program. Concurrent with this expanded audit effort, the California State Controller notified the California Department of Health Services of the problems discovered and recommended actions to tighten processes to prevent fraudulent practices from occurring in the future. In addition, cases of suspected fraud disclosed through the audits were referred to the California Department of Justice for criminal investigation.

At the same time, the California State Controller joined with the Federal Bureau of Investigation, the U.S. Attorney's Office, and the California Department of Justice to form a joint task force. These federal and state agencies began investigating and prosecuting providers that the California State Controller's audits had identified as potentially fraudulent.

Fraud in the California Medi-Cal Program

Once enrolled by the Department of Health Services as a California Medi-Cal provider, an individual potentially can bill the program for services not provided. As the payment process is highly automated, a provider can generate a high volume of invoices through electronic means. The California State Controller's Office, as the state's payment disbursing agent, has developed a computer program that tracks provider billing trends.

However, even when suspected fraudulent providers are identified through the California State Controller's tracking system, it is often too late to recover money paid. Some providers simply disappear with millions of dollars in program funds. In some cases, fraudulent providers have submitted new applications and been approved as providers again with full billing privileges. The Federal Bureau of Investigation has estimated Medi-Cal fraud to be in excess of $1 billion per year.

Accomplishments of the California State Controller's Office

Since the Long Beach audits, the California State Controller's Office has continued to identify widespread fraud and billing abuse in various segments of the Medi-Cal fee-for-service non-institutional provider population. A total of 367 audit reports have been issued on Medi-Cal providers for the period of January 1, 1995, through June 30, 2000. Chart 1 below identifies, by year, the number of reports issued for the four types of Medi-Cal providers audited by the California State Controller's Office.

Chart 1: Audit Reports Issued

Year	Pharmacy	Durable Medical Equipment	Laboratory	Physician/ Doctor	Annual Total
1995	5	0	0	0	5
1996	14	1	2	2	19
1997	37	1	4	3	45
1998	55	35	10	13	113
1999	10	124	4	7	145
2000	0	35	5	0	40
Total	121	196	25	25	367

The 367 audits conducted by the California State Controller's Office identified a total program cost savings of over $547 million. This amount includes $141 million in overpayments to providers and nearly $385 in estimated savings through cost avoidance. Cost avoidance is defined as the estimated amount of payments saved by the Medi-Cal program as a direct result of the California State Controller's Office actions. An additional $21 million in rebates from manufactures of Factor 8 and Factor 9 blood clotting agents for hemophiliacs was also recovered as a result of the California State Controller's Office efforts. Chart 2 identifies the amount of questioned cost, cost avoidance, and Factor 8 and Factor 9 rebates secured from manufacturers by year. A further breakdown of this audit effort, identifying total program savings by Medi-Cal provider type, is reflected in Chart 3.

Chart 2: Savings From Audits

Year	Questioned Cost	Cost Avoidance	Total	Factor 8 and 9 Rebate	Annual Total
1995	$ 30,796	—	$ 30,796	—	$ 30,796
1996	3,742,265	$ 21,037,444	24,779,709	$ 2,338,712	27,118,421
1997	20,415,550	56,102,615	76,518,165	5,091,769	81,609,934
1998	40,615,060	167,482,810	208,097,870	3,800,203	211,898,073
1999	49,572,738	90,752,970	140,325,708	8,405,429	148,731,137
2000	26,659,028	49,338,420	75,997,448	1,726,938	77,724,386
Total	$ 141,035,437	$ 384,714,259	$ 525,749,696	$ 21,363,051	$ 547,112,747

Chart 3: Savings by Provider Type

Year	Pharmacy	Durable Medical Equipment	Laboratory	Physician/ Doctor	Factor 8 and 9 Rebate	Annual Total
1995	$ 30,796	—	—	—	—	$ 30,796
1996	4,079,797	$ 128,964	$ 18,910,862	$ 1,660,086	$ 2,338,712	27,118,421
1997	18,454,328	1,211,039	42,178,278	14,674,520	5,091,769	81,609,934
1998	52,187,378	50,753,438	84,367,171	20,789,883	3,800,203	211,898,073
1999	3,185,011	83,668,421	26,330,516	27,141,760	8,405,429	148,731,137
2000	—	24,798,091	51,199,357	—	1,726,938	77,724,386
Total	$77,937,310	$160,559,953	$222,986,184	$ 64,266,249	$ 21,363,051	$ 547,112,747

Prior to a federal court determination in 1999, the California State Controller's Office used its authority under state law to initiate withholds of $23.5 million in payments to 135 providers that had overbilled the Medi-Cal program and made 238 referrals to the Department of Justice for criminal investigation and prosecution.

Moreover, the California State Controller sponsored state legislation to tighten up program controls at the state level. Chart 4 identifies program problem areas and corresponding legislative changes that were enacted into law and are being implemented by the California Department of Health Services.

Chart 4: Legislation Sponsored by the California State Controller

Problem identified	Legislative remedy
The Department of Health Services issues provider numbers to individuals with demonstrated history of questionable billing practices.	• Give the Department of Health Services authority to deny applications for providers who have a history of questionable billing practices. • Require individuals applying for provider numbers to disclose any past involvement in the program as well as any pending audits, audit appeals, and investigations. This is applicable to all of the individual's family members as well.
Auditors lack access to records for supplies and products, with the exception of incontinence products.	• Give auditors clear legal authority to access all records deemed necessary to validate the payments. • Extend the recordkeeping requirement to manufacturers and dealers of non-incontinence supplies.
Existing law does not require an individual whose medical license (physician, pharmacist, etc.) was used to obtain a Medi-Cal provider number to be the owner of the business. Unqualified individuals are paying medical professionals for use of their license number to qualify for Medi-Cal provider numbers.	• Require applicants for provider numbers to disclose whether they are the actual owners of the business.
The Department of Health Services does not have authority to recover overpayments to non-institutional providers through payment withholds while an audit finding is appealed, even though that authority exists for institutional providers.	• Extend the Department of Health Services' authority in this area to non-institutional providers.
Lack of state bonding requirements allows providers to disappear when audits disclose significant billing abuses, except for suppliers of incontinence products.	• Impose bonding requirements on all non-licensed providers.
Providers who had committed fraud were required to pay it back but there were no interest requirements or penalties, except for certain providers.	• Impose interest charges on all overpayments. • Impose monetary penalties when the overpayments resulted from fraud.

In recognition of the significance of problems identified by the California State Controller's Office audits, the California Legislature has approved and budgeted additional resources for both the California Department of Health Services and the California Department of Justice to increase prevention efforts and to apply criminal and civil penalties to fraudulent providers. The California Department of Health Services strengthened controls over the enrollment of providers to screen out providers that might commit fraud. Resources have been added to help identify potential fraud and to stop payments until reviews can be made. The California Department of Justice has used its resources to file criminal actions against fraudulent providers.

The increased anti-fraud activities from state and federal agencies are having some effect on decreasing the amount of fraudulent activities in the Medi-Cal program. The California Legislative Analyst's Office noted that 31% of the providers of durable medical equipment products had been removed from the provider rolls and that claims for this group have declined by nearly 10%. Durable medical equipment providers were one of the first provider types targeted by the California State Controller's Office audits. In addition, the California Legislative Analyst's Office notes that similar results are expected in future years in the other provider types that have been targeted by the California State Controller's Office.

New Emerging Fraud Techniques

One new fraud technique involves the use of false identifications for licensed providers. Applications for provider status have been found containing information about doctors who are no longer practicing or not practicing in the State.

Also, many fraudulent providers are now using "marketers" or "cappers" to obtain cooperation of Medi-Cal beneficiaries in their schemes. The providers pay "marketers" or "cappers" between $100 and $130 for each referral. The "marketers" or "cappers" pay a beneficiary a sum of money in exchange for using his or her Medi-Cal card to bill for services not provided. In some cases, providers have stolen Medi-Cal beneficiary information from hospital records and used it to bill for services.

The use of fictitious documents requires that additional audit procedures be developed to detect this practice. Also, many providers are choosing to administratively appeal audit findings with the California Department of Health Services in order to avoid payment for as long as possible. These techniques require additional state staff resources and increase the time necessary to start a restitution process.

Another scheme practiced by providers who leave or are removed from the rolls is to buy an established health care business and start billing under that name.

Also, in an attempt to create some documentation to avoid detection, fraudulent providers are now performing unnecessary invasive procedures (e.g., drawing blood) and then billing for tests never performed. In addition to the health risks to the person having the procedure, this practice can increase the possibility of the spread of disease in the general population.

It must be concluded that the fight against fraud in the Medi-Cal program is still far from over. However, just at the time when new and enhanced efforts are needed to continue this fight in all its varying forms, recent federal court decisions have severely limited the California State Controller's role in combating this fraud.

The Federal Court Decisions

The California State Controller's Office established a highly effective pre- and post-payment audit function, which resulted in significant savings to taxpayers by promptly identifying and curtailing persons and entities engaged in questionable and abusive billing activity in many state-operated programs. In addition, the California State Controller's independent constitutional and statutory duty under California law, to determine the legality and propriety of payments involving state general funds, allowed her to initiate withholds on payments to Medi-Cal providers with audits showing potential fraudulent practices as well as to make referrals for criminal investigations to the California Department of Justice and the Federal Bureau of Investigation.

However, in November 1997, a Medi-Cal provider filed a lawsuit to compel the State Controller to pay approximately $3 million in Medi-Cal claims that had been withheld by the California State Controller's Office because there was insufficient information concerning the services provided and because the claimed amounts were unusually high for the services provided. The issue raised in the lawsuit was whether the California State Controller could independently withhold alleged overpayments from Medi-Cal providers.

Even though the California State Controller has an independent duty under California law to determine the legality and propriety of payments, federal courts have determined that the State of California modified this duty when it accepted federal money and agreed to be bound by the federal Medicaid law, and federal regulations, which require a single state agency to administer Medi-Cal payments. In California, that agency is the Department of Health Services. The federal court, Eastern District, ruled that the federal law and regulations prevent the California Department of Health Services from delegating any authority to exercise administrative discretion in the State's Medi-Cal program, including independently withholding a provider's payments. The federal court decision required the California State Controller to release the $3 million to the provider.

A subsequent federal court ruling, brought by a provider who pled guilty to Medi-Cal fraud, determined that the California State Controller cannot independently select and initiate audits of Medi-Cal providers. To do so, in the court's opinion, would be an exercise of discretion that is impermissible under the Medicaid program.

Although the California State Controller's Office continues to audit Medi-Cal providers, it does so through an interagency agreement with California Department of Health Services. Under terms of the agreement, the California State Controller's Office must audit only those providers which the California Department of Health Services selects. Moreover, the California State Controller's Office must present findings relative to these audits to the California Department of Health Services without expressing any opinion about the cause of the overpayments or recommending a course of action.

The federal court decisions resulted in delays in issuing audits that were in progress and in beginning new audits while new procedures and processes were developed to comply with them. For the current year, the California State Controller's number of completed audits is significantly less than for previous years. Moreover, the inability to initiate audits or take immediate corrective action (i.e., withholds, referral for criminal investigation) means that the California State Controller's efforts are greatly diminished.

Solutions to the Imposed Constraints

The independence of the California State Controller's Office has been instrumental in identifying the problem of fraud in the Medi-Cal program and in taking or encouraging actions to increase prevention and detection. Given that fraudulent providers are becoming even more creative, the independent role of the California State Controller is even more important than ever. Post-payment audit efforts alone will not be sufficient to effectively address these problems. The California State Controller will continue to coordinate her audit efforts with the California Department of Health Services as required by the court ruling, but to act most effectively, she must have the authority to operate in the independent manner that was so critical to identifying the cases of fraud in the first place.

Federal Medicaid law and regulations regarding the role of the single state agency should be revised to allow the California State Controller, and similarly situated Controllers in every other state, to carry out his or her independent duties and responsibilities as the superintendent of fiscal affairs. This would allow the California State Controller to return to analyzing the Medi-Cal program to identify fraudulent trends, initiate audits to identify overpayments, take actions to withhold payments make referrals for criminal prosecution, and develop recommendations to increase prevention and detection of fraud.

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